Proactive Psychiatric Consultations – Proposal to Replicate an Initiative from Yale

(Torrey 4-14-13)

Dartmouth-Hitchcock seeks to enhance the value of healthcare, improve our financial position, and contribute to the literature on healthcare improvement. We propose to advance to these three strategic goals by replicating the Yale model of proactive psychiatric consultations on medical inpatients (Desan, Zimbrean, Weinstein, et al. 2011).

The Yale project: Desan and colleagues (2011) added proactive psychiatric consultation to a busy, short-stay, hospitalist-staffed general medical unit. They first piloted the project adding only a psychiatrist who reviewed each new inpatient on a medical inpatient unit (26 patients). Each weekday, the psychiatrist met with the medical team to review all admissions, identify potential psychiatric issues, initiate consultations immediately, and to follow-up on previous recommendations. Comparing this intervention with periods of time on the same unit before and after the intervention, they found that more than half the admitted patients had mental health needs and that the intervention significantly reduced length of stay (2.90 +/- 2.12 versus 3.82 +/- 3.30 days). The percentage of patients with lengths of stay >4 days was significantly reduced from 27.9% to 14.5%.

Based on this success, they then implemented a proactive consultation team (0.5 FTE psychiatrist, 1.0 FTE nurse specialist, 1.0 FTE social worker, and a .17 FTE ARNP) that covered 75-80 medical inpatients (see enclosed Powerpoint presentation). The multidisciplinary team added resources to work with the medical social workers and nurses to implement recommended plans. The intervention resulted in a significant reduction in length of stay (average of 1.3 days), use of constant companions (“sitters”), and denied days. There was also a non-statistically significant reduction in 30 day readmissions. Cost analysis demonstrated a 4.2 ratio of financial benefit to cost when counting benefits (reduced denied days, reduced constant companion use, marginal cost/day of saved through reduced length of stay, and revenue enhancement from filling freed up beds with new patients) against the personnel cost of the intervention team.

The Yale team notes that the general medical physicians, nurses, and social works are very grateful for the service. Much of the service is educational with the intent to educate others to a degree that they put themselves out of business over time. The service also has been gradually been working to reduce variability by developing clinical pathways for common difficulties found on medical inpatient units such as delirium, substance abuse, and suicidality. Based on their positive clinical and financial experience, hospital administration at Yale has funded expansion of this service to their entire inpatient medical service at the hospital (3.0 FTE social workers, 2.25 FTE ARNPs, 1.75 FTE psychiatrists plus weekend moonlighters for 450 beds) and is planning to extend it to a new hospital that they have recently acquired.

Our proposal: We propose to replicate the Yale intervention, including the clinical and economic evaluation. A replication will entail proactive consultations, a multidisciplinary team, and access to administrative data in order to evaluate the intervention. We will need a comparison group, which can either be a parallel service or a before and after design.

The senior leader of the Yale intervention, William Sledge MD, has invited us to observe their service and indicates he will come up to provide us with advice at our site. He has also offered to help us evaluate such a replication. He can provide some funding and technical assistance for the evaluation.

We have just hired a new consultation-liaison psychiatrist who will start this summer. This provides us with the psychiatric staffing required for the replication. Our intervention team would consist of 0.5 FTE psychiatrist, a 1.0 FTE social worker, and 0.2 FTE of an ARNP psychiatric liaison nurse. Estimated personnel cost for this clinical team is $272,000. We would look for resources to support the evaluation.

This proposal promotes the core values and goals of DHMC. The system will learn from the experience and we have a high likelihood of improving the value of care at DHMC and improving financial performance. We have a high likelihood of success because of the clarity of the model, the support from Dr. Sledge, the good working relationships between inpatient medicine and psychiatry, the support of the Department of Psychiatry leadership, the availability of psychiatric staffing, and the quality of the consultation-liaison team under the remarkable leadership of Christine Finn MD.

Desan PH, Zimbrean PC, Weinstein AJ, Bozzo JE, & Sledge WH: Proactive Psychiatric Consultation Services Reduce Length of Stay for Admissions to an Inpatient Medical Team. Psychosomatics, 52:513-520, 2011.